STRONGER MEDICINE

RESTORING THE FINANCIAL HEALTH OF NEW HAMPSHIRE'S COMMUNITY HEALTH CENTERS

A Report of the Community Health Centers Capital Finance Work Group

Convened under the auspices of the New Hampshire Charitable Foundation

OCTOBER 2001

Community Health Center
Capital Finance Work Group Members

Charlton MacVeagh Jr., Chair

Bryan Ayars, Department of Health & Human Services, Bureau of Rural Health & Primary Care

David C. Bliss, NH Health & Education Facilities Authority

Thomas G. Bunnell, NH State Affairs Director, Bi-State Primary Care Association

Allison Coleman, Capital Link

Martin L. Gross, Sulloway & Hollis, PLLC

Kenneth Jue, Executive Director, Monadnock Family Services

Henry D. Lipman, Executive VP/CFO, Lakes Region General Hospital

Thomas G. Moran, US Department of Health & Human Services HRSA

Sandra Pelletier, Executive Director, Area Agency for Developmental Services Of Greater Nashua, Inc.

Jeff Pollock, President, MerchantBanc

Richard J. Ramsden

Nadine Salley, NH Community Loan Fund

Richard Silverberg, Executive Director, Health First Family Care Center

Michael Swack, Director, Community Economic Development Program, New Hampshire College

Gregory White, CFO, Manchester Community Health Center

Adjunct Members

Laura Coleman, Director of Community Health, Bi-State Primary Care Association

Lewis Feldstein, President, NH Charitable Foundation

Tess Stack Kuenning, Executive Director, Bi-State Primary Care Association

Lori Real, Director, Department of Health & Human Services, Office of Planning & Research

Jeanne C. Ryer, Senior Program Officer, NH Charitable Foundation

The CHC Capital Finance Work Group would like to gratefully acknowledge the thoughtful contributions of Bruce Sptiz of Spitz Consulting Group to its work and the assistance of Tina Spinney of the New Hampshire Charitable Foundation in organizing our meetings.

For more information, contact Jeanne C. Ryer, Senior Program Officer, New Hampshire Charitable Foundation, 37 Pleasant Street, Concord NH 03301 **.**

Executive Summary

The Community Health Centers (CHCs) Capital Finance Work Group was convened by the New Hampshire Charitable Foundation at the request of the Commissioner of Health and Human Services for the State of New Hampshire to look at capital finance issues facing the state's CHCs. The Work Group, comprised of leaders from business and finance, hospitals, state and federal government, health centers, and others, met over a six-month period in 2001.

New Hampshire's CHCs are key to delivering health services to the state's uninsured and underinsured residents, providing comprehensive primary care to more than 40,000 New Hampshire residents last year. From 1994 to 1999, the financial position of the CHCs deteriorated, primarily because their numbers of uninsured patients increased dramatically. Over this period, the health centers did not generate enough cash internally through operations to meet their capital investment needs for property, plant and equipment and to keep up with rising operational costs. The current economic downturn will create even more pressure on CHCs.

The Work Group came to a clear position supporting the importance of the CHCs as safety net providers in the state and an endorsement of the mission to provide access to primary health care broadly throughout the state through a number of models. Achieving a sustainable funding stream is key to that mission, as it is to the near-term financial health and survival of the existing CHCs.

The original charge was to identify CHC capital needs and sources of capital. Early on, the Work Group concluded that addressing capital needs without addressing the continual revenue shortfalls of the CHCs would not be productive or responsible. Thus, the group focused discussions on two areas: increasing revenues and resources for CHCs and improving CHC finance and operations, recognizing that, without revenue increases, improvements in finance and operations would have limited results.

The Work Group identified the following stakeholders with significant interests in maintaining CHCs financial health and identified potentially helpful stakeholder actions:

- State of New Hampshire
- Hospitals
- Business
- Philanthropy
- Non-Profit Sector
- Communities

The CHCs total capital needs are approximately $8 million for facilities, major equipment, and refinancing. The total revenue shortfall for all of the CHCs from operations, based on the most recent two years available, was about $750,000. Although these are big problems and big dollars for the CHCs, they are not, in the realm of health care expenditures, "big money." ***This is a problem well within reach of a solution.***

The Work Group identified a number of opportunities to improve the financial health of the CHCs primarily by developing statewide capacity to increase resources and to increase operational efficiency. Recommendations fall into the following areas, with specific recommendations outlined in the report.

- Increasing revenue or resources – Immediate infusions of cash and MIS resources are needed. Also needed are improvements in reimbursements, local and statewide fundraising, and stronger collaborations with health care institutions. Systems change with an income stream to cover the uninsured is essential for the health and survival of the CHCs. Statewide development effort is needed to increase charitable giving to CHCs.
- Reducing costs – Already lean, CHCs could still benefit from participation in purchasing pools, reducing debt carrying costs, shared staffing, equipment, and other resources with other CHCs or local hospitals. CHCs need to develop statewide capacity to work effectively as a group to maximize cost reduction opportunities.
- Improving operational efficiencies –Prospective payments and more rapid cost settlement from the State of NH could improve CHC cash flows. Common information systems and increased electronic medical records and billing capacity could improve CHC operational efficiency
- Increasing access to capital – CHCs need statewide capacity to identify and seek lending options.
- Increasing public awareness –CHCs need statewide capacity to establish a CHC brand identity as providers of quality, comprehensive health services to all, regardless of ability to pay, and to promote themselves as an important local health care charity.

Background

At the request of Donald Shumway, Commissioner of Health & Human Services for the State of New Hampshire, and in response to the Department of Health and Human Services, Office of Planning and Research report, “Strengthening the Safety Net: A Financial Analysis of New Hampshire's Community Health Centers,” the New Hampshire Charitable Foundation convened a working group to assess and make recommendations to promote the financial health of New Hampshire’s Community Health Centers (CHCs). The members of the Community Health Center Capital Finance Work Group were drawn from all sectors, including business and finance, community leaders, state and federal government, other stakeholders, and the health centers themselves. The Work Group members were very generous with their time and expertise, committing many hours of time over the six months of the process.

New Hampshire’s Community Health Centers are key to delivering health services to our uninsured and underinsured residents (See CHC list and map, pp. 12-13). The CHCs provided care to more than 40,000 New Hampshire residents last year, 40% to 60% of CHC patients are without insurance. Between 1994 and 1999, the financial position of the CHCs deteriorated, primarily because the number of their uninsured patients increased dramatically. By Fiscal Year 1999, total margins ranged from 2% to -4%. Over this period, the health centers did not generate enough cash internally through operations to meet their capital investment needs for property, plant and equipment and the rising costs of operations.

The financial challenges faced by the CHCs are well documented in the State’s report and need not be revisited here. Certainly, the current economic downturn and increasing numbers of uninsured patients will only worsen the situation. The Work Group came to a clear position supporting the importance of the CHCs as safety net providers in the state and an endorsement of the mission to provide access to primary health care broadly throughout the state through a number of models. Achieving a sustainable funding stream is key to that mission, as it is to the near-term financial health and survival of the existing CHCs.

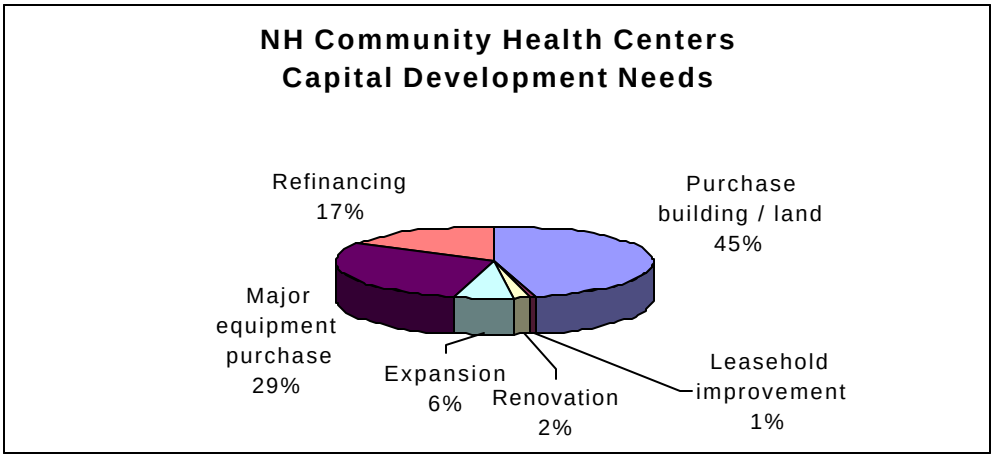
Scope

The original charge to the Work Group was to review current information on the capital needs of the health centers, and to identify possible sources of funding for these capital needs. Early in the discussions, the Work Group concluded that to address capital needs only, without addressing the continual revenue shortfalls of the CHCs, would not be productive or responsible. As a result, the group focused their discussions in two areas: increasing revenues and resources for CHCs and improving CHC finance and operations, recognizing that, without increased revenues, any improvements in finance and operations would yield limited results.

The Work Group had the benefit of several work products, including “Strengthening the Safety Net: A Financial Analysis of New Hampshire's Community Health Centers,” authored by health care analyst Nancy Kane, DBA, for the NH DHHS Office of Planning and Research and “New Hampshire Health Centers Capital Needs Assessment Survey Report,” authored by Allison Coleman of Capital Link for Bi-State Primary Care Association. Bi-State Primary Care Association, the membership organization of the Community Health Centers in NH and VT, made additional data on health center finances available to the Work Group.

How Big Is This Problem?

New Hampshire has a total of ten CHCs, of which eight are freestanding, non-hospital based health centers. The data below is based on the financial statements and reported capital needs of six of the freestanding CHCs; over the course of the years studied, two CHCs have merged and another has been developed out of the merger of two local health agencies. The capital needs of the New Hampshire's CHCs total approximately $8,000,000 for facilities acquisition and improvements, for expansion, for capital equipment (largely information systems and upgrading to electronic medical records) and for refinancing.



The total dollars needed to address the aggregate capital needs of the CHCs and erase their revenue shortfall over the past two years is estimated at under $10 million, not a small amount of money, but certainly not large in the realm of health care expenditures.

In 2000, 50% of CHCs operated in the red, with a total loss from operations of more than $325,000 in 2000. Although not every CHC has lost money every year, and one or two have investment and other income that has offset losses from operations, the trend is clear.

NH CHCs Operating Losses & Mean Operating Margins
1997-2000

Year	2000	1999	1998	1997
% CHCs w/loss	50%	38%	50%	50%
Aggregate Loss from Operations	$(326,023)	$(427,313)	$(250,755)	$(490,419)
Mean Operating Margin	-1.2%	.5%	1.5%	-2.3%

Note: The total number of CHCs varies over these years because of mergers between existing CHCs and new CHCs.

It is worth noting that, although the CHCs have identified their capital needs as stated above, many are unable to use further debt financing to address the needs, because of their limited ability to meet added debt obligations. Indeed, the CHCs have operating margins that are insufficient to support normal requirements, much less additional debt.

Who Should Care and Who Can Help?

The Work Group quickly reached an understanding of the role and importance of New Hampshire's CHCs in providing health services to those not currently well served by the rest of the health system, including residents of rural areas and inner city neighborhoods, non-English speaking residents, the working poor, the uninsured, low-income and otherwise economically disadvantaged residents. The CHCs promote a comprehensive approach to patient care that addresses all of the patient's and family's barriers to health and health care.

The Work Group concluded that the financial and organizational health of New Hampshire's non-profit CHCs is the legitimate concern and responsibility of New Hampshire business, health care, non-profit, and government sectors. Losing even one CHC creates losses in the whole system of health care safety-net providers that has ramifications for the individual patients, the businesses they work in, the communities they live in, and the state as a whole. Specifically, the Work Group identified the following stakeholders with significant interests in maintaining CHCs financial health and identified potentially helpful stakeholder actions.

- **State of New Hampshire** – CHCs are an essential provider for state-funded programs and services. The State of New Hampshire can improve its payments to CHCs and streamline the way it works with them so CHCs can be more efficient. Last year the NH DHHS presented a budget package that included a number of items that would have significantly benefited the CHCs, including improved reimbursements, funding for needed services, and funding to support improved medical information systems. Funding of those items not approved in the original request could provide much needed assistance to the CHCs.
- **Hospitals** – CHC services help maintain health and reduce the burden of illness in particularly vulnerable populations, lowering hospitals' uncompensated care costs by managing chronic conditions in primary care rather than as acute inpatient care episodes. Hospitals can include CHCs as key providers in their operations, provide them with cash grants, shared facilities, services, staff, and equipment. All of these contributions to CHCs could be considered Community Benefits for non-profit hospitals.
- **Federal Government** – The federal government provides a range of funding to states and directly to federally funded and federally designated CHCs. Currently only four New Hampshire CHCs are federally funded (under the PHS Act 330) and designated as Federally Qualified Health Centers (FQHC), which provides them with favorable Medicaid reimbursement rates and a federal grant. Two more have the designation of "Federally Qualified Health Centers (FQHC)-Look-Alike" that provides them with favorable reimbursement, but not a federal grant. In the recent past, the criteria for establishing more federally funded CHCs under PHS Act 330 are skewed against areas that, like much of New Hampshire, predominately rural with a small minority population. Changes to federal regulations need to recognize the serious challenges to providing community health services to communities with large numbers of elderly and "working poor" residents. Funds for more 330-funded CHCs are needed for New Hampshire. Another federal program (the 340B drug pricing program) provides very favorable drug pricing for qualified CHCs, but federal assistance with start-up costs is needed. And finally, the issue of uninsurance, which is a root cause of the CHCs financial strain, requires federal and state attention.
- **Business** -- CHCs provide health care services to low-wage workers and those without health insurance, and they create healthier communities. CHCs contribute to their local economies as employers and purchasers of goods and service. Businesses can contribute to CHCs either statewide or locally, with cash or in-kind donations. Businesses can offer staff and executive expertise to CHCs for Board or Advisory

Committee service. Businesses can take advantage of several tax-advantaged opportunities to provide loans or grants to CHCs.

- **Philanthropy** -- CHCs are key to providing comprehensive health services to the most vulnerable of the State's residents. Philanthropy can support CHCs through grants for programs, by supporting increased capacity and improved statewide services, and by making program-related investments in CHCs.
- **Non-Profit Sector** -- CHCs serve as a referral point, provide quality health care regardless of ability to pay, and act as a referral source for patients with complex social and family issues who need services. Non-profits can support CHCs by joining in collaborative services.
- **Communities** -- CHCs improve the health of the whole community by focusing comprehensive health and preventive services for those least likely to be able to access them. Communities can include CHCs in their United Way and other fund-raising efforts and support them. Communities can support their CHCs by promoting them as quality health providers for those with and without health insurance.

Key Issues

The Work Group identified several key issues facing the CHCs:

- Inadequate income stream – Revenues from operations are insufficient. Increasing numbers of uninsured and underinsured patients using the CHCs as their primary health care source bring little or no payment for services. New Hampshire's CHCs generate little in non-grant fund-raising income compared with their counterparts in other states. CHCs designated as Federally Qualified Health Centers receive enhanced Medicaid payments for their Medicaid patients, but not all health centers are so designated and increasing numbers of CHC patients lack Medicaid, Medicare, or private insurance.
- Inadequate cash reserves – CHCs as a group have little cash available for operations. CHC staff spend inordinate amounts of time managing cash and seeking and managing grants to supplement inadequate reimbursements. CHC executives are masters at managing with little cash but that comes at a cost in attention to other issues.
- Lack of capital – CHCs lack efficient access to capital and in some cases lack the ability to support debt. Although capital requirements vary, each CHC has some need for new or restructured debt capital. CHCs as a group are undercapitalized; several need facility enhancements, almost all need equipment; some have current debt that could be restructured to their advantage. Although the statewide and local banks have working relationships with the CHCs, some of the CHCs can not participate in typical business loans because of their size or inadequate margins. Some CHCs need access to short-term credit.
- Variation in operations – CHCs vary in size, structure, staffing, payor mix, and productivity. Although each CHC has evolved its model in response to local needs, they are not effectively able to model and share best practices across the CHCs except in a limited way. Because CHCs are for the most part small and managed as individual, community-based non-profit corporations, they do not generally benefit from shared resources or group problem solving. The CHCs have devoted resources to some shared services, but opportunities are limited by resources and time.
- Low public awareness – CHCs are generally not well understood beyond their patient and provider community. Greater awareness of CHCs as quality health care providers and as important health care charities is essential.

Recommendations

The Work Group identified a number of opportunities to improve the financial health of the CHCs and to help assure their continued ability to provide quality health services to their patients. A clear thread in the list below is the need to maximize revenues first, and then to develop statewide capacity to develop additional resources, communicate a clear CHC message, and maximize opportunities to increase efficiencies and finance debt capital. Not only are the CHCs all separate organizations, but most are at a scale where the executive director must wear many administrative hats. The ability to develop some shared CHC staff capacity would seem essential to accomplish many of these recommendations.

- Bring immediate resources to CHCs to mitigate their losses and help them improve their management systems. – The Work Group recommends that stakeholders identify sources of funds for supplemental grants for cash relief for the CHCs and resources to help the CHCs upgrade their MIS systems to improve billing and cash management and practice management systems.
- Increasing revenue or resources – The Work Group sees opportunities for the CHCs to improve reimbursements through higher rates per visit, restructuring reimbursable visit types, extending favorable reimbursement status to more health centers, creating fund raising and development capacity both statewide and locally to increase revenue from fund-raising, developing shared services and/or equipment agreements with local health care and other institutions. CHCs also may need to compete more effectively for insured patients to improve their own payor mix. Systems change that includes an income stream to cover the uninsured is essential for the long-term health and survival of the CHCs.
- Reducing costs -- Although the CHCs run very lean operations, some added resources could lead to lower costs of operations. Examples may include participation in large health care purchasing pools, reducing debt carrying costs, shared staffing, equipment, and other resources with other CHCs or local hospitals. CHCs need to develop statewide capacity to work effectively as a group to maximize cost reduction opportunities.
- Improving efficiency of operations – CHCs could benefit from more efficient relationships with the State of NH to support payments for patient services, for cost settlements, and for grant and contract services. Streamlining State cost settlement, grant, and contract procedures could also improve organizational efficiency by better deploying CHC staff. Currently not all CHCs are positioned to benefit from some streamlined processes already offered by the State. Significant opportunities exist to pool resources to improve medical records and information systems and to improve medical staff productivity. CHCs need to develop systems for working together and sharing resources that will allow them to seek out and take advantage of these opportunities for shared systems and shared expertise.
- Increasing access to capital – CHCs vary in their capital needs, but all need improved access to debt capital. Assistance with identifying specific needs for each CHC, identifying sources of capital, and pulling packages together is essential. The Work Group sees opportunities to package tax-credited loans and grants and loan guarantees to develop funds or lower interest rates. CHCs need to establish some centralized expertise to develop and package these opportunities.
- Increasing public awareness -- CHCs need to establish a brand identity as a provider of quality, comprehensive health services to all, regardless of ability to pay, and to promote themselves as an important local health care charity. CHCs need to develop statewide communications capacity to develop and deliver the message locally and statewide.

Immediate Action Recommendations

Develop statewide capacity to improve CHCs communications, fundraising and financial operations.

The Work Group feels strongly that the CHCs, although structurally well suited to respond to and benefit from their status as locally based organizations, need to develop statewide capacity and staff that can serve all of the CHCs and develop expertise in fundraising, communications, and financial operations. Bi-State Primary Care Association, as the statewide organization of CHCs, seems particularly well positioned to provide these functions on a shared basis and distribute personnel and financial resources. These functions should include the capacity to raise funds statewide and to distribute those funds to local CHCs, to train local CHC boards and staff on both annual and capital fundraising, to develop expertise in planned giving, to develop and implement coordinated statewide and local communications plans, and to train local staff. In the finance area, capacity should include the ability to work with and provide ongoing technical assistance to local CHCs to secure new and restructured debt and loan guarantees, develop and implement group purchasing strategies with other large purchasers, and establish uniform data systems.

The Work Group strongly endorses efforts by Bi-State Primary Care Association to seek funding to support such capacity development with a goal of beginning implementation by year end. The Work Group will also offer itself as individuals to serve as an advisory group to any such effort.

Identify immediate resources to mitigate the losses of the CHCs who are most at risk and to improve their management systems.

The Work Group recommends that stakeholders identify sources of funds for supplemental grants for cash relief for the CHCs and resources to help the CHCs upgrade their MIS systems to improve billing and cash management and practice management systems. Losses from the last two years totaling $750,000 place several CHCs at serious risk. In addition, the eight non-hospital CHCs need $1.2 million ($150,000 per CHC) to upgrade to a common medical information and billing system that would improve financial management and reporting and improve practice management and medical records information. A federal grant of approximately $500,000 may be available, but the remaining funds must be found.

The Work Group encourages stakeholders to look for sources of grant and other funds to address the revenue shortfall for the past two years and to assist the CHCs in upgrading MIS systems.

Work with CHCs to identify sources of credit for line-of-credit and equipment loans and package these loans and guarantees to reduce interest rates to the CHCs

Some CHCs have no access to lines of credit; others pay high interest rates. Managing cash is a constant struggle for CHC staff. Other CHCs need equipment loans, particularly to upgrade information systems. The Work Group recommends working with CHCs and lenders to package loans using tax-advantaged sources and if necessary philanthropic guarantees to reduce interest rates. The Work Group also specifically recommends using the structures of the Community Development Finance Authority, the Health and Education Finance Authority, the Business Finance Authority to provide financing at below-market rates and tax-advantaged opportunities for corporate lending and philanthropy.

The Work Group recommends that Bi-State Primary Care Association seek funds work with the CHCs to identify capital needs, develop loan packages, and present to potential lenders.

Work with the State of New Hampshire to streamline the grants and contracts application and payment processes.

CHCs rely heavily on grant and contract payments for State of New Hampshire services. The system for applying (even on a continuation basis) for these grants and contracts is universally described as time-consuming and cumbersome. Once awarded, reimbursement under the grants and contracts tends to be slow and billing cumbersome, as well. Because CHCs operate with tight resources and little cash reserves, the time spent to manage the application and billing processes is a considerable drain on the CHCs. The State and the CHCs have been working on this issue for some time, with some limited improvements and plans for further improvements under discussion. Federal requirements tied to specific funding sources create challenges for the State on this issue.

The Work Group recommends that the State of New Hampshire work to streamline the application process, effective with the next application cycle. The Work Group further recommends that the State pay out these grants and contracts prospectively on a monthly or quarterly basis, and that the CHCs come to agreement on a common standard for these prospective payments.

Work with the CHCs and the State of New Hampshire to move all CHCs to electronic billing, institute a prospective payment system for Medicaid reimbursement, and streamline the Medicaid cost settlement process.

As noted above, CHCs are working with little in cash reserves and spend inordinate time in managing cash flow. Currently some CHCs are able to use the State's electronic Medicaid billing system, but some are not. Universal electronic billing would increase the efficiency of CHC staff, improve cash flows, and reduce interest costs. As noted above, several CHCs need to improve their medical information systems in order to institute electronic billing, but lack the necessary funding.

The State and the CHCs are currently discussing the necessary changes to move federally funded and qualified CHCs to a prospective Medicaid payment system consistent with recent federal requirements, but again, among the other challenges, CHCs need improved medical information system capabilities

CHCs are heavily dependent on Medicaid reimbursement, and for federally funded and qualified CHCs, a lengthy cost settlement process is required to establish the actual cost-based reimbursement rate. CHCs would benefit from a faster and more streamlined cost settlement process.

The Work Group recommends that the CHCs and Bi-State Primary Care Association work with the State of New Hampshire to identify resources to move all CHCs to a common medical information system that will allow electronic Medicaid billing, a prospective payment system and a more efficient cost settlement system by June 2002.

Intermediate Efforts

Work with CHCs to develop and track a set of financial benchmarks and service data benchmarks that will help the stakeholders monitor the health of the CHCs.

As independent non-profit organizations, CHCs are accountable to their local Boards of Directors, but we all have a stake in their organizational health. An annual financial and services report on the collective health of CHCs would help assure stakeholder and community accountability for providing adequate support for CHCs and assure CHC accountability for fiscal health and staying on mission.

The Work Group recommends that the CHCs work with Bi-State Primary Care Association and NH DHHS to identify, develop, and track financial and service data

benchmarks to monitor CHC performance and improve stakeholder and CHC accountability.

Increase the number of federally funded CHCs in New Hampshire.

Only four of New Hampshire's' CHCs are federally funded through the US Public Health Service (PHS 330 funding). Federal funding provides an additional annual grant of approximately $300,000 to each designated health center. Current efforts at the federal legislative level to increase the number of federally funded health centers could make more funds available. New Hampshire has four CHCs currently receiving the PHS 330 operational funding. Two federally qualified "look-alike" CHCs are well positioned to be eligible for these grants if funding is extended and the two CHCs score well on eligibility criteria.

New Hampshire has been disadvantaged in the federal scoring system, because it has a relatively healthy population, a low minority population, and is largely rural. Recent changes to the scoring system make New Hampshire more competitive. If federal funds are available, New Hampshire needs to make sure that it has several competitive CHCs ready to apply for the new funds.

Additional federal programs may be available that would provide additional financial assistance to the federally qualified CHCs, including loan pass-through programs and construction programs. A currently available federal pharmacy program could dramatically lower drug costs for CHCs, but the start-up cost is high.

The Work Group members will work with Bi-State Primary Care Association, the State of New Hampshire DHHS, the federal DHHS, and the New Hampshire congressional delegation to maximize opportunities for New Hampshire to receive additional federal CHC funds. Potential gain is approximately $600,000 per year near term for two of the most financially vulnerable CHCs and additional $600,000 per year in grants if two more CHCs meet eligibility requirements. The potential of additional funds for construction and financing is not known at this time. NH DHHS and Bi-State Primary Care should work with the NH congressional delegation to explore improved access to federal resources for CHCs.

Increase hospital support of CHCs through encouraging community benefits contributions of cash grants, facilities use, shared services, shared equipment and other resources.

Each CHC operates within the service area of at least one non-profit hospital. Hospitals benefit greatly from CHC operations in their area; many have been instrumental in establishing and supporting their local CHC. The Work Group encourages the hospitals, individually and through their association, to work with CHCs to develop greater collaborative opportunities that will provide stable relationships and dependable access to health care for each community's vulnerable residents. Examples might include cash grants; donated services, e.g., biomedical engineering; donated space; donated or shared equipment; shared staff; opportunities to participate in continuing education; opportunities to use specialized resources, e.g., productivity analysis; etc.

The Work Group encourages the NH Hospital Association and Bi-State Primary Care Association to convene a meeting of CHC and hospital executives to explore collaboration strategies.

Investigate restructuring of Medicaid reimbursements to provide survivable payment rates to CHCs.

CHCs are heavily dependent on Medicaid reimbursement. Innovations and restructuring of Medicaid reimbursement for CHCs could improve the financial sustainability of the CHCs. Possibilities include adjustments to the Medicaid rate structure and changes to allowable visit types to include reimbursement for preventive health services such as disease management, group visits, telemedicine visits and other innovations, and wrap-around services, such as medical translation and nutrition education. The State also could consider a State Qualified Health Center reimbursement rate, similar to the Federally Qualified rate, that could be extended to qualified CHCs that do not meet the federal criteria, usually because of their organization's governance structure.

The Work Group recommends that the State of New Hampshire, DHHS work with Bi-State Primary Care Association to improve the Medicaid reimbursement options for all CHCs and encourages the DHHS to study which reimbursement changes would have the greatest impact on CHC bottom lines.

Long Term Efforts

Develop a sustainable funding stream to provide for the cost of health care for New Hampshire's uninsured and underinsured residents.

The Work Group noted that a key element for sustainable CHC operations is an adequate income stream to support the increasing numbers of uninsured patients who seek care at the community health centers. Although the Work Group acknowledges that the following options would require the building of public and political will, it feels obligated to note the following possible sources of funds for supporting health care for the uninsured:

- Medicaid Disproportionate Share Funds. The State of New Hampshire receives between $70 and $80 million annually in Disproportionate Share Medicaid funds from the federal government which it uses to support its general fund obligations, even though the intent of the federal program is to target funds for institutions that provide a disproportionate share of the care to low-income individuals. Even a small proportion directed to CHC care for the low income and uninsured could erase the CHCs financial problems and assure adequate health care access. Recent changes in federal regulations may require the State to use a specified proportion of these funds for health care.
- Tobacco Settlement Funds. The State of New Hampshire receives more than $40 million annually from the national settlement of tobacco litigation, intended to replace state funds that were expended in care of patients with tobacco related disease. With the exception of a relatively small amount for tobacco prevention, these funds go to the State's general operating fund. A high percentage of CHC patients suffer from and receive ongoing care for tobacco related illness. Again, even a portion of New Hampshire's tobacco settlement funds, proportionally targeted directly to CHC care for the low income and uninsured, could erase the CHCs financial problems and assure adequate health care access.
- Proposed Tobacco Tax Increase. Consumer and health advocacy groups in each of the six New England states are promoting a New England-wide $.50 increase in the state tax on tobacco products. The legislative proposal in New Hampshire would dedicate revenues generated by the tobacco tax increase to health care access for seniors and the low income and working poor uninsured in the state. Revenue from the proposed tobacco tax increase in New Hampshire is estimated at $60-plus million a year. An amendment is being considered that would specifically target a portion of the tax increase revenue to CHC care for the

uninsured, helping to ameliorate the CHCs financial problems and assure adequate health care access.

- Expanded Access to Health Insurance. About 100,000 New Hampshire residents do not have health insurance; most are adults who are working, but in jobs that do not provide any or at least affordable health insurance plans. State-led efforts to provide health coverage to these individuals, through public-private mechanisms similar to the Healthy Kids program, could provide all New Hampshire residents with access to health care and provide the CHCs, who currently serve many of them well, with adequate reimbursement for their care.

New Hampshire's Community Health Centers

Ammonoosuc Community Health Services
PHS 330 Funding and Federally Qualified Health Center
Littleton, Warren, Whitefield
Additional services site: Woodsville

Avis Goodwin Community Health Center
Federally Qualified Health Center-"Look-alike"
Rochester, Dover

Capital Region Family Health Center
Hospital-based, Concord Hospital
Concord, Hillsborough

Coos County Family Health Services
PHS 330 Funding and Federally Qualified Health Center
Berlin
Additional services sites: Colebrook, Lancaster

Families First of the Greater Seacoast
Portsmouth

Health First Family Care Center
Federally Qualified Health Center-"Look-alike"
Franklin

Lamprey Health Care
PHS 330 Funding and Federally Qualified Health Center
Newmarket, Nashua, Raymond

Manchester Community Health Center
PHS 330 Funding and Federally Qualified Health Center
Manchester

Partners in Health Center
Hospital based – Valley Regional Hospital
Newport

White Mountain Community Health Center
Conway
Additional services site: Wolfeboro

Community Health Center Market Areas